mercy care

**Fax completed prior authorization request form to** 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/chp-forproviders/pharmacy

# Interferons
# Pharmacy Prior Authorization Request Form

**Do not copy for future use. Forms are updated frequently.**

**REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis**

| **Member Information** | | | |
|---|---|---|---|
| Member Name (first & last): | Date of Birth: | Gender: ☐ Male ☐ Female | Height: |
| Member ID: | City: | State: | Weight: |

| **Prescribing Provider Information** | | | |
|---|---|---|---|
| Provider Name (first & last): | Specialty: | NPI# | DEA# |
| Office Address: | City: | State: | Zip Code: |
| Office Contact: | Office Phone | Office Fax: | |

| **Dispensing Pharmacy Information** | | |
|---|---|---|
| Pharmacy Name: | Pharmacy Phone: | Pharmacy Fax: |

| **Requested Medication Information** | | | |
|---|---|---|---|
| ☐ Alferon N | ☐ Intron A | ☐ Pegasys | ☐ Actimmune |
| ☐ Other, please specify: | | | |

| | | | | |
|---|---|---|---|---|
| Are there any contraindications to formulary medications?<br>If yes, please specify: | ☐ Yes | ☐ No | ☐ New request | ☐ Continuation of therapy request |
| What medication(s) has member tried and failed for this diagnosis? | | | | |

| | | | |
|---|---|---|---|
| Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No | Diagnosis: | | ICD-10 Code: |
| Directions for Use: | Strength: | | Dosage Form: |
| | Quantity: | Day Supply: | Duration of Therapy/Use: |

| **Turn-Around Time for Review** | |
|---|---|
| ☐ Standard – (24 hours) | ☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.<br>Signature: _____ |

**Clinical Information**

**☐ Chronic Hepatitis B**

| | | | |
|---|---|---|---|
| Current lab reports to support the following: | ☐ Documentation ALT ≥2 times ULN | ☐ Documentation of elevated Hepatitis B Virus DNA level | ☐ Above 2,000 IU/mL Hepatitis B e-antigen negative |
| | ☐ Significant histologic disease | ☐ Above 20,000 IU/mL Hepatitis B e-antigen positive | |

| | | |
|---|---|---|
| Is there evidence of compensated Liver disease? | ☐ Yes | ☐ No |

**☐ Renewal ONLY:**

| | | | | | |
|---|---|---|---|---|---|
| Is lab report supportive of Hepatitis B e-antigen POSITIVE? | ☐ Yes | ☐ No | Is lab report supportive of Hepatitis B e-antigen NEGATIVE? | ☐ Yes | ☐ No |

**☐ Follicular Non-Hodgkin's Lymphoma (Stage III/IV)**

| | | |
|---|---|---|
| Will requested medication be given in conjunction with anthracycline-containing combination chemotherapy? | ☐ Yes | ☐ No |

**☐ Acquired Immune Deficiency Syndrome (AIDS)-Related Kaposi's Sarcoma**

| | |
|---|---|
| Confirm member age per above: | Confirm provider specialty per above: |

**☐ Hairy-Cell Leukemia**

| | | |
|---|---|---|
| Did member have less than a complete response to cladribine or pentostatin? | ☐ Yes | ☐ No |
| Was there a relapse after <2 years of demonstrating a complete response to cladribine OR pentostatin? | ☐ Yes | ☐ No |

| | | | | | |
|---|---|---|---|---|---|
| ☐ **Renewal ONLY:** | | | | | |
| Is there evidence of disease progression? | | | | ☐ Yes | ☐ No |
| ☐ **Chronic Granulomatous Disease** | | | | | |
| Confirm member age per above: | | | Confirm provider specialty per above: | | |
| ☐ **Renewal ONLY:** | | | | | |
| Is there evidence of disease progression? | | | | ☐ Yes | ☐ No |
| ☐ **Malignant Osteopetrosis** | | | | | |
| Confirm diagnosis per above: | | | Confirm provider specialty per above: | | |
| ☐ **Renewal ONLY:** | | | | | |
| Is there evidence of disease progression? | | | | ☐ Yes | ☐ No |
| ☐ **Condylomata acuminata - Genital or Venereal Warts** | | | | | |
| Is requested medication for intra-lesional use? | ☐ Yes | ☐ No | Are the lesions small and limited in number? | ☐ Yes | ☐ No |
| Did member have trial and failure with TOPICAL treatments (for example, imiquimod cream, podofilox)? | | | | ☐ Yes | ☐ No |
| Was there trial and failure with a surgical technique (for example, cryotherapy, laser surgery, electrodessication, surgical excision)? | | | | ☐ Yes | ☐ No |
| ☐ **Renewal ONLY:** | | | | | |
| Was there at least 3 months between treatments, unless lesions grow, or new lesions appear? | | | | ☐ Yes | ☐ No |
| **Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.** | | | | | |
| | | | | | |

**Signature affirms that information given on this form is true and accurate and reflects office notes.**

**Prescribing Provider's Signature:** _____ **Date:** _____

**Please note: Incomplete forms or forms without the chart notes will be returned**

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 833-711-0776 to check the status of a request.